State of West Virginia ★ Public Employees Insurance Agency

Health Benefits Enrollment Form

HEALTH

Complete this form to enroll for health coverage. Complete all sections of the form except "AGENCY."

EMPLOYEE

Name (Last)	(First)	(MI)	(Generation: Jr., Sr., etc.)	Social Security Number

Street Address	County of Residence	Home Phone ( )

City	State	Zip	Job Title	Work Phone ( )

Sex (Circle One) M F	Date of Birth (mm/dd/yyyy)	Other Insurance (Plan Name) If Any

Do you wish to participate in the IRS Section 125 Premium Conversion Plan sponsored by PEIA, if available? YES ☐ NO ☐

If you do not wish to participate in any PEIA health coverage, please sign this box and return this form to your benefit coordinator. I decline to participate in the health coverage.

Signature: Date:

FAMILY INFORMATION

Is spouse currently insured by PEIA as a policyholder? ☐ Yes ☐ No If yes, enter spouse's Social Security Number: _____

Please complete the following information for all dependents who will be covered under your plan:

Name Last, First, MI, Generation)	**Address** (If different from above)	**Relationship (Circle One)**		**Sex/ Category**	**Birth Date**	**Social Security Number**	**Other Insurance** (Plan Name)
	----------	SP	CH				
	----------	SP	CH				
	----------	SP	CH				
	----------	SP	CH				
	----------	SP	CH				

CATEGORY for Dependent Child(ren): ***Relationship Code*** **1.** *Child (biological or adopted)* **2.** *Step-child* **3.** *Grandchild* **4.** *Court-Ordered Dependent Child* **5.** *Student (age 19-25)* **6.** *Other* In dependent column titled "Sex/Category", please include both gender and relationship code (e.g., M1 for Male Child; F3 for Female Grandchild; F25 for Female Step-child/Student, etc.). *If adding a dependent child other than your biological or adopted child, documentation is required showing legal guardianship of the child.*

COVERAGE

COVERAGE SELECTION (Select One) I am enrolling for:

- 1 ☐ Employee Only
- 2 ☐ Employee/Child(ren) Only
- 3 ☐ Family
- 4 ☐ Family with Employee Spouse

Please indicate the plan in which you are enrolling by checking the box beside the plan option you choose:

- 1 ☐ PEIA PPB Plan A
- 2 ☐ PEIA PPB Plan B
- 3 ☐ PEIA PPB Plan C
- 4 ☐ The Health Plan HMO Plan A
- 5 ☐ The Health Plan HMO Plan B

AFFIDAVITS

Tobacco Affidavit: Please mark which members of the family use tobacco and sign the form. If none of the people enrolled on your PEIA coverage uses tobacco, you will receive the discount on your health and life insurance premiums I acknowledge by signing the Acceptance box below that WVPEIA or its agents have access to my medical records to check my tobacco use status.

Who uses tobacco: ☐ Policyholder ☐ Dependent (spouse and/or children)
☐ No Tobacco Users within the last six (6) months

Living Will Affidavit: PEIA offers a premium discount to health policyholders who have executed a Living Will/Advance Directive. If you have a valid living will, please check the box beside the statement below and sign the form.

☐ By checking this box, I acknowledge that I have executed a valid Living Will or advance directive, and that I have discussed its contents with the appropriate parties, including my family and my health care provider.

ACCEPTANCE

I hereby accept the group coverage I have indicated above. I understand that the PEIA may change the types or levels of benefits or the amount of contribution. I certify that the above information is true and correct and understand that providing false information on this form is illegal and that those who provide false information may be prosecuted. I hereby consent, for myself and my covered dependents, to the release to PEIA and to the plan I have selected, of all medical and prescription drug information needed to process claims, determine coverage, review utilization, investigate complaints, assess quality of care, evaluate plan performance or any other process involved in my treatment, payment of claims or health care operations.

Employee's Signature: Date:

To Be Completed By The Employer:

AGENCY

Agency Name		Account Number		Date of Employment
Hours Worked Weekly	**Effective Date of Coverage**	**Index Code**	**Region**	**Coverage Code**

I hereby certify that, to the best of my knowledge, the information contained herein is accurate. I further certify that the employee is a permanent full-time employee of this agency who meets the minimum eligibility requirements for the Public Employees Insurance Plan.

Authorized Signature: Date:

Please send only the original to PEIA

Revised December 15, 2010

MEMO

To: PEIA Eligibility Document Unit

From: _____ Date: _____
(policyholder's name)

RE: Unique ID Number | | | | | | | | | | | | | | | | | **OR**

Last four digits of SSN [redacted] - [redacted] - | | | |

Please mark in the left column the type of transaction you are documenting and the documentation attached.

	Status Change Event	**Documentation Required**
	Divorce	Provide a copy of the divorce decree showing that the divorce is final.
	Marriage	Copy of valid marriage license or certificate.
	Birth of Child	Copy of child's birth certificate.
	Adoption	Copy of adoption papers.
	Adding coverage for a stepchild who resides with the policyholder	Copy of child's birth certificate.
	Adding coverage for any other child who resides with the policyholder	Copy of court-ordered guardianship papers
	Open Enrollment under spouse's employer's benefit plan	A copy of printed material showing open enrollment dates and the employer's name.
	Death of spouse or dependent	A copy of the death certificate.
	Beginning of spouse's employment	A letter from the spouse's employer stating the hire date, effective date of insurance, what coverage was added, and what dependents are covered.
	End of spouse's employment	A letter from the spouse's employer stating the termination or retirement date, what coverage was lost, and dependents that were covered.
	Significant change in health coverage due to spouse's employment	A letter from the spouse's insurance carrier indicating the change in insurance coverage, the effective date of that change and dependents covered.
	Unpaid leave of absence by employee or spouse	A letter from your or your spouse's personnel office stating the date that you or your spouse went on unpaid leave or returned from unpaid leave.
	Ineligibility of dependent due to coverage available from his or her own employer	A letter from the dependent's employer stating that coverage is available.
	Change from full-time to part-time employment of vice versa for employee or spouse	A letter from you or your spouse's employer stating the previous hours worked, the new hour worked, and the effective date of the change.

I understand that PEIA cannot process my enrollment or change in enrollment for me and my dependents until these documents have been received.

Please send this documentation checklist cover sheet with your documents to the address below.

601 57th St., SE – Suite 2 – Charleston, WV 25304-2345